CLEAR FORM

FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT
HUMAN RESOURCES DEPARTMENT

FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT
2021 Health Plan Enrollment

Circle one: New Hire Add / Dele Dependent Marriage Divorce Other_____

Effective Date:

Part-time or Full-time Employee? PT / FT

Medical Plan Election (must select one and indicate which family tier you elect)

☐ **I Choose: Plan "A"**
☐ **I Choose: Plan "B"**
☐ **I Choose: Plan "C"**

☐ **Employee Only**
☐ **Employee & Spouse**
☐ **Employee & Children**
☐ **Employee & Family**

OR

☐ **I Waive Medical Coverage**
Waiver Form Required

Dental, Vision, and Audio Election (must select one) (Cost is per pay period)

I Choose Dental, Vision, and Audio

☐ **Employee Only $15.12**
☐ **Employee & Children $20.16**
☐ **Employee & Spouse $20.16**
☐ **Employee & Family $25.25**

☐ I Waive Dental, Vision, and Audio

EMPLOYEE INFORMATION:

_____/_____/_____ _____/_____/_____ _____

Social Security Number **Last Name, First Name, Middle Initial** **Date of Birth** **M/F**

_____ _____ _____ _____

Mailing Address **City** **State** **Zip Code**

Is this a change of address? **Yes / No**

Phone Number: ( ) _____

Email Address _____

DEPENDENT INFORMATION:

Complete for each eligible dependent to be covered by this plan

Relationship Codes: **S** = Spouse (married); **C** = Natural Child/Step Child/Adopted Child /Legal Guardianship of Child

Last Name, First, MI	Gender M / F	Date of Birth	Social Security Number	Relationship Code	Other Coverage? Y /N
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			

I hereby certify that the above information is true, correct and complete to the best of my knowledge. I have received a copy of the current Health Plan and agree to comply with all Plan provisions as a condition of receiving benefits. I understand that benefits provided under the Health Plan for which a third party is or may be liable are subject to all of the subrogation and recovery provisions of the Plan. I have read and understand the options available to me regarding Health Benefits and understand I am unable to make any changes to my election during the calendar year unless I have a qualifying status change (marriage, divorce, birth, adoption, death or change in employment status) and have made my election change within 30 days of the date of the qualifying change. **Failure to submit a timely change and supporting documentation may carry financial consequences and/or the inability to make a change except during the open enrollment period.** Please see reverse side for important information regarding Section 125 Flexible Spending. Attached are copies of the appropriate marriage and/or birth certificates, court-approved adoption (or fully executed adoption pre- agreement with appropriate parties), legal guardianship, divorce, and/or name change or other legal documentation, as well as the applicable FNSB forms for Adoption, Guardianship, or Name Change. The above information will be used to determine eligibility for claim/benefit purposes. If you a) enroll a dependent who does not meet the eligibility requirements of this plan; or b) fail to notify the plan of your divorce or other loss of dependent eligibility within 30 days of the event; you are intentionally misrepresenting a material fact and the plan will retroactively terminate coverage for your ineligible dependent. If the plan pays claims based on your misrepresentation, your dependent may be terminated retroactively and you may be responsible for any claims paid on your dependent's behalf. **I authorize the FNSB School District to make payroll deductions to cover my share of the cost of this health benefit plan.**

_____ _____

Employee Signature Date

(Rev. 12/2020)

OPTIONAL / VOLUNTARY BENEFITS (must enroll each year)**:**

Flexible Medical Spending Arrangement (Medical FSA) $_____/_____= $_____
(Minimum $200; Max $2,750 Annually) **Annual Election Amount** **Amount per pay period**
(May not elect HSA and medical FSA in same tax year)

Flexible Dependent Care Spending Account (Dependent FSA) $_____/_____= $_____
(Minimum $200; Max $5,000 Annually) **Annual Election Amount** **Amount per pay period**

Health Savings Account (HSA) $_____/_____= $_____
(Eligible with Plan B ONLY) **Annual Election Amount** **Amount per pay period**
(Maximum $3,600 Single or $7,200 Family) ☐ **Yes, I elect to take the employer contribution to an HSA**
(May not elect HSA and medical FSA in same tax year; see eligibility requirements)

Health Reimbursement Arrangement (HRA)
(Eligible with Plan C ONLY) ☐ **Yes, I elect to take the employer contribution to an HRA**

Section 125 – Medical and Dependent Care Spending Account Guidelines:

- **I understand that if the dollars allocated for reimbursement to me under the provisions of this plan are not used for such benefits, the balance of the unused amounts must be forfeited ("Use it or lose it"). Unused amounts cannot be carried forward into the next plan year.**
- **Medical expenses reimbursed under this plan are not eligible as tax deductions on my federal income tax return.**
- **Medical expenses for reimbursement include certain expenses incurred during the plan year for the diagnosis, cure, mitigation, treatment, or prevention of disease for which there has been no other reimbursement through insurance, damages, or otherwise. Certain cosmetic surgery expenses and medical insurance premiums are not eligible for reimbursement.**
- **I understand that during an unpaid leave of absence, contributions to the medical expense reimbursement account must be made on an after-tax-basis- just like any insurance premiums. When I return to work, the pre-tax contribution will resume. In most cases, no change may be made in the medical expense reimbursement account except for termination of the plan due to termination of my employment. For special rules affecting your plan, please contact you're the benefits team.**
- **If I terminate my employment and do not elect to continue my medical expense account payments on an after-tax basis, only expenses incurred during the period of coverage will be reimbursed. Coverage under the reimbursement account ceases when the payments cease.**
- **Dependent care expenses reimbursed under this plan are not eligible for the dependent care tax credit on my federal income tax return.**
- **Dependent care expenses eligible for reimbursement must be provided by third parties meeting both applicable state law requirements and federal tax law requirements.**
- **Claims may only be made for dependent care that has already been provided. The amount allocated by federal tax law is $5,000 (or $2,500 if married and filing separately) for the calendar year.**
- **I understand that I will receive expense vouchers to assist in filing for the expense reimbursement and in keeping track of eligible expenses under the plan.**
- **I understand that I must complete a voucher and submit it with proper documentation in order to be reimbursed for any expenses on a timely basis.**
- **I understand that I must submit documentation as requested for all expenses reimbursed under this plan.**
- **I agree to notify my employer if there is reason to believe that any item for which reimbursement has been made is not allowable under the terms of the Plan.**
- **I understand that the premiums under Section 125 cannot be revoked or changed during the Plan year. The only exception is that you may change your election on account of and consistent with an IRS approved change of family status (e.g. marriage, divorce, death of a spouse or child, birth or adoption of a child, change of employment status of a spouse). The election change must be requested within 30 days of the event and must be on account of and consistent with the change in family status as defined in the Plan. My participation in this Plan terminates on the last day of the Plan year. Before the beginning of each Plan year, I will be offered the opportunity to change my election for the following Plan year.**

HSA Eligibility Notice

- If you are claimed as a dependent on someone else's taxes or are covered by any other health insurance policies that are not considered HDHPs, including Medicare and unlimited Flexible Spending Accounts, you are not eligible for an HSA.
- If you participate in an unlimited FSA or HRA through your employer or your spouse's employer, you are not eligible for an HSA.
- You and your spouse can each have an HSA if you both have high deductible coverage. If you have family HDHP coverage, the maximum contribution is split equally unless you and your spouse agree on a different division.

_____ _____
Employee Signature Date (Rev. 12/2020)

Office Use Only:
Effective Date of Coverage:_____ Docs on File? Y / N Missing Documentation:_____

Employer HSA contribution:_____ Employer HRA contribution:_____ HR Initials:_____